CHILD HEALTH CARE ACCESS PROBLEM IDENTIFICATION

This form tracks and documents information about barriers to health care access for children. Please type or print clearly. Forward the completed form to your local CHDP Deputy Director for review, ***and*** send a copy to your region's program manager:

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1. Date form completed (mm/dd/yy)	2. Client's county of residence	3. Client's age	4. Client's gender ☐ Female ☐ Male

5. Check if:
- ☐ Foster child
- ☐ Relative placement
  If yes, county of origin:
- ☐ Other (specify):

6. Area of service difficulty:
- ☐ Well Child
- ☐ Medical
- ☐ Pharmacy
- ☐ Vision
- ☐ Nutrition
- ☐ Dental
- ☐ Mental Health
- ☐ Audiology
- ☐ Other (specify):

7. Name

Social security number (required only for Healthy Families problem)

8. Client race/ethnicity/language *(if applicable to problem/issue)*

9. Client's type of insurance coverage:
- ☐ Medi-Cal Managed Care Plan (plan name):
- ☐ Non-Medi-Cal Managed Care Plan (plan name):
- ☐ Mental Health Medi-Cal Managed Care
- ☐ Fee-for-Service Medi-Cal
- ☐ Healthy Families (plan name):
- ☐ Children's Treatment Program (Prop 99)
- ☐ None
- ☐ Other insurance (specify):

10. Type of problem: (check all that apply)
- ☐ Enrollment/automatic default
- ☐ Disenrollment
- ☐ Health Care Options materials/presentation
- ☐ Provider assignment
- ☐ Service authorization
- ☐ Language/cultural-related
- ☐ Provider not accepting client's health insurance
- ☐ Eligibility (specify as follows):
  - ☐ Willingness to apply for Medi-Cal or Healthy Families
  - ☐ Ability to pay premiums/share-of-cost
  - ☐ Immigration Status/Public Charge
- ☐ Other (specify):

Provide brief explanation of the problem, resolution, and outcome:

Resolution achieved: ☐ Yes ☐ No

11. Source of information (e.g., social worker, health professional, client)	12. Time spent addressing access issue
13. Completed by	14. Phone number (include area code)